Click on a field and type in your information. Plan year amount(s) are automatically totaled. Print the form and mail or fax.

2008 Election Form
State of Tennessee
Flexible Benefits Plan

Treasury Department
10th Floor Andrew Jackson Building
Nashville, TN 37243-0228
(615) 741-3131 or Fax (615) 401-6815
www.treasury.state.tn.us/flex

Note: Complete this form only if you wish to participate in the Medical or Dependent Day Care Reimbursement Plan.

Please print using a ballpoint pen.

Last Name	First Name	M.I.	Social Security No.

Home Address (Street)	City	State	Zip	Work Phone

Department Name	Allotment Code	Payroll Frequency (Paychecks Per Year)	Date Employed	Enrollment Status
		☐ 12 ☐ 24 ☐ Other ____		☐ Annual Enrollment ☐ New Hire

Reimbursement Account Enrollment: (New elections must be filed for 2008)

Indicate the amount you wish to contribute to a reimbursement account through tax-free salary reduction by completing the sections below. If you have questions, contact your personnel office for additional literature or call (615) 741-3131.

In Box #1, indicate the reduction amount per pay period. In Box #2, indicate the number of regular payroll checks you expect to receive during the 2008 plan year. Consult your payroll office if you are unsure of how many checks you will receive. In Box #3, indicate the total dollar amount you elect to contribute for the 2008 plan year.

Medical Expense Reimbursement Account			Dependent Day Care Reimbursement Account		
Maximum allowable annual contribution is $7,500.			TAX FILING STATUS (PLEASE CHECK ONE): ☐ Married, filing separately (maximum-$2,500) ☐ Married, filing jointly (maximum-$5,000) ☐ Head of household (maximum-$5,000)		
Box #1 Reduction Per Regular Paycheck		_____	**Box #1** Reduction Per Regular Paycheck		_____
Box #2 Number of Regular Paychecks Expected	X	_____	**Box #2** Number of Regular Paychecks Expected	X	_____
Box #3 Total Plan Year Dollar Amount	=	$0.00	**Box #3** Total Plan Year Dollar Amount	=	$0.00

IMPORTANT

- I understand this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- I hereby authorize my employer to reduce my gross salary before federal, state, and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I file an approved Family Status Change.
- I understand that any amount remaining in any Reimbursement Account that is not used during the plan year will be forfeited since it cannot be carried to the next plan year.
- I understand and agree that the state will not incur any liability resulting from either my participation in or my failure to accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I forego my right to participate during the upcoming plan year.

Employee Signature	Date Signed